

GEORGIA STATE BOARD OF WORKERS' COMPENSATION**NOTICE OF INTENT TO BECOME A PARTY AT INTEREST**

Instructions: Any group insurance company or other health care provider who has made payments on the employee's behalf or provided medical services and who wishes to be named a party at interest to obtain reimbursement for those expenses which have been paid, shall file this form with the State Board of Workers' Compensation, 270 Peachtree Street, N.W., Atlanta, Georgia 30303-1299.

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Social Security Number	Date of Injury
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A. IDENTIFYING INFORMATION

EMPLOYEE	County of Injury	Address	
Employee E-mail			
EMPLOYER	Name	INSURER/ SELF-INSURER	Name
Address		CLAIMS OFFICE	Name
		Address	
Employer E-mail		Claims E-mail	

B. NOTICE

Notice is hereby given that: _____ (Print Name of Provider)	
Address	Phone
	E-mail
has made payments or provided medical services in the amount of \$ _____ on the employee's behalf for medical treatment, and desires to be made a party at interest in this claim in order to demonstrate that the employer/workers' compensation carrier are responsible for reimbursement for funds so expended, should liability be established under Title 34-9.	

C. CERTIFICATION

<input type="checkbox"/> I hereby certify that I have sent a copy of this form to all parties and counsel in this claim, and to the State Board of Workers' Compensation, 270 Peachtree Street, N.W., Atlanta, Georgia 30303-1299		
Print Name Here	Signature	Date
Phone	E-mail	

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT <http://www.sbwcc.georgia.gov>

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO \$10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).